REGULAR ARTICLE

Expedited Diversion of Criminal Defendants to Court-Ordered Treatment

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The authors propose a formal statutory diversion process for offenders with serious mental disorders: expedited diversion to court-ordered treatment (EDCOT). As a civil commitment proceeding accompanied by dismissal of criminal charges, EDCOT would not entail a waiver of criminal trial rights and could be invoked even if the defendant lacked trial competence. EDCOT would also be available to authorize civil hospitalization of offenders who are not immediately able to function successfully in the community. These provisions, coupled with mandated compliance with outpatient treatment and judicial supervision, would enable diversion of many, perhaps most, offenders with serious mental disorders into a treatment system that could provide acute services, discharge planning, and problem-solving management in the community.

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Over the last 50 years, as the number of public hospital beds has decreased without offsetting increases in community services and supports, individuals with mental disorders increasingly have come to be arrested, jailed, and punished.[1,2] Numerous studies have documented the large numbers of disordered individuals who have entered the criminal justice system. Steadman and colleagues reported a prevalence of 14.5 percent of serious disorders (i.e., bipolar, depressive, and psychotic disorders) among male jail inmates; among female inmates, the prevalence was higher at 31 percent.[3] A Bureau of Justice Statistics survey noted significant mental illness in 16.2 percent of state prisoners, 7.4 percent of federal prisoners, 16.3 percent of jail inmates, and 16.0 percent of those on probation.[4] On the basis of these figures, it has been estimated that more than 800,000 individuals with mental illness are under correctional control at any given time: an estimated 180,000 state prisoners, 8,000 federal prisoners, 97,000 jail inmates, and 547,000 on probation.[5]

Beginning in the 1990s, diversion programs have been implemented to reduce the number of arrestees with serious mental illness who are incarcerated. Across the United States, the most recent estimates have reported 560 diversion programs in operation for arrestees with mental illness who would otherwise be in jail[6] and 350 to 500 mental health courts.[2,7,8] Characteristics of mental health courts have been extensively reviewed.[2,9,10] In summary, they are specialty criminal courts that operate under existing prosecutorial and judicial authority, typically without specific governing statutes. Each local mental health court must be designed, planned, funded, and staffed by the agreement of various stakeholders, including the judiciary, prosecutors, defense bar, and community providers. In addition, the stakeholders must

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agree on defendants' clinical and legal eligibility criteria. Defendants' participation in mental health courts is voluntary. Therefore, defendants must be competent to stand trial and agree to the diversion to mental health court. The legal process either involves a conditional guilty plea or, in some courts, a pread-judication suspension of proceedings for the duration of court-supervised treatment with the expectation that the charges will be dropped upon successful completion. Defendants must be functioning sufficiently well to be placed in the community and receive outpatient services. As the cited figures indicate, diversion programs have not been broadly implemented, and these innovations have had little aggregate national impact on the increasing flow of mentally disordered individuals entering the criminal justice system. Clearly there is room for new approaches.

We propose a new form of diversion designed to expedite the treatment of many offenders with serious mental illness early in the process of criminal justice involvement. This new form of civil commitment is termed expedited diversion to court-ordered treatment (EDCOT). EDCOT differs in fundamental ways from most current diversion efforts that typically are one-off programs designed to fit within the existing framework of the criminal process and typically depend on informal partnerships and locally available resources.[11] EDCOT entails formal termination of the criminal process in favor of a formal civil commitment governed by a specific statute prescribing criteria and procedures, with an accompanying funding appropriation.

EDCOT is designed to be a rapid path into needed treatment for offenders with serious mental disorders, including both inpatient and outpatient services as warranted. In cases involving acutely ill defendants who lack decisional capacity, an EDCOT commitment would not require the defendant's consent, and the delays and costs associated with determination and restoration of competence to stand trial in criminal cases would be avoided. Further, because inpatient treatment options would be available, EDCOT would apply to many defendants with serious disorders who are not eligible for entry into currently available diversion programs and, all too often, become enmeshed in a misshapen process for restoring trial competence.

We hasten to add, however, that EDCOT would also provide an efficient pathway for formal diversion of presumed competent defendants to the civil system when the prosecution and defense agree to do so. We expect that a formal EDCOT commitment, accompanied by dismissal of the criminal charges, would be attractive to both sides in many cases involving defendants with serious mental illness.

Implementation of EDCOT would require enactment of a new civil commitment statute with statewide application. As a result, there would be substantial standardization across court programs, legislative policy affirmation by and support from the state mental health agency, and over time redirection of state resources (e.g., the provision of beds and related treatment funds). In contrast, current diversion programs vary widely with respect to the clinical characteristics and diagnoses eligible, the seriousness of criminal charges targeted, the length and degree of court oversight, the treatment and social services provided, and the goals of diversion.[10,12] As a result of the bottom-up development of diversion programs, they are difficult to implement, may not survive the loss of key personnel or program champions, and may fail due to unstable funding.

It is our hope that EDCOT will be used to channel a large proportion of offenders with serious mental illness into a treatment-oriented system within weeks after arrest. Admittedly, such expedited decision-making will require fundamental changes in the rhythm of the criminal process, but the current practice is rife with inefficiencies, pointless proceedings, and "procedural minuets" (Ref. 13, p 605). Perhaps these frustrations can convince all of the participants and stakeholders that making a definitive decision early in the process is in everyone's interest. The relevant inquiries are if an EDCOT commitment serves the interests of the defendant and if it serves the interests of society better than criminal prosecution.

Our aim is to encourage this conversation. We note that EDCOT, as described in this article, is a preliminary proposal intended to stimulate further discussion; it is not intended to be a finished product.

Implementation of EDCOT will require the allocation of significant resources for the care and management of committed offenders. The costs of these new services would eventually be offset by the elimination of expenditures required for processing

defendants with serious mental illness within the criminal justice and forensic mental health systems. We begin with a review of these systems and their costs. We then present the proposed objectives and procedures for EDCOT, which would reduce these costs and improve the care and management of offenders with serious mental disorders.

Mentally Disordered Defendants

Criminal Courts and the Forensic System

Following arrest, mentally ill offenders enter a labyrinthine criminal process. Many will enter the forensic mental health system, which leads to long delays in adjudication of cases. These delays add legal costs and substantial expenditures for specialized assessments and, often, hospitalizations.

To proceed to adjudication, all defendants must be competent to stand trial (CST). Bonnie,[14] citing legal authority and precedent,[15–17] summarized it this way:

> The proposition that a defendant's incompetence bars adjudication is deeply rooted in the common law, has been constitutionalized by the U.S. Supreme Court, and is taken as axiomatic in the administration of criminal justice. The Supreme Court has adopted prophylactic procedural requirements to induce trial judges to order mental evaluations, and to hold hearings, whenever significant doubts are raised regarding a defendant's mental competence. In addition, a defense attorney's failure to seek a mental evaluation in doubtful cases is likely to invalidate any resulting conviction. These rules are designed to accomplish the dual purposes of assuring a fair adjudication and of preserving finality by having all doubts regarding the defendant's mental condition raised and resolved as early in the process as possible (Ref. 14, p 291).

The forensic system has evolved in response to these constitutional demands, which are explicitly and fundamentally related to the processing of defendants in the criminal justice system, not to serving the treatment needs of disordered defendants. The forensic system involves initial assessments of CST to identify those who are incompetent to stand trial so they can be ordered to receive treatment designed to restore competence. Published estimates of the annual number of competence evaluations range from 19,000 to 60,000,[18,19] but these estimates have uncertain grounding. The true figure of CST evaluations performed annually is likely much higher. Historically, defendants were committed to state hospitals (often high-security, specialized forensic facilities) for inpatient assessments of CST.[20] The trend in recent decades, however, has been to perform evaluations on an outpatient basis, and 19 states now conduct most of their evaluations in the community, although this usually means in the local jail because the defendants typically remain in custody. Some states have reported an increasing demand for inpatient evaluations.[20]

The annual cost of jail-based CST evaluations has been estimated to be $50 million.[21] This is likely an underestimate because it is based on only 20,000 evaluations per year, and the projected costs were based solely on jail expenses. This figure does not include payments to evaluators, which have been reported to range from $300 to $3,000 per case in the public sector.[20] If one assumes an average payment of $1,000 per case, this adds $20 million to the aggregate annual costs of jail-based evaluations.

Expenditures on inpatient evaluations are more readily quantified. The Substance Abuse and Mental Health Services Administration's data from 2014 indicated an average census of 3,375 mentally disordered defendants hospitalized for pretrial evaluations in 30 states. Assuming an average hospitalization for CST assessment lasts 30 to 60 days, this would indicate that 20,000 to 40,000 CST evaluations are performed each year in those states on an inpatient basis. On the basis of bed occupancy, the cost of pretrial CST evaluations in state facilities is more than $1 billion per year.[22] These figures for jail-based and state hospital-based evaluations do not include the costs of attorney time, court personnel, clerical staff, or transportation.

Many defendants who are found to be incompetent to stand trial are committed to state hospitals for restoration. The rate of incompetent to stand trial determinations among CST referrals varies, with reported ranges of 7 percent to 70 percent and a mean of 27.5 percent.[23] In 2014, states reported an average census of 4,562 individuals hospitalized for restoration at an annual cost of $1.36 billion.[22] This estimate does not include the federal criminal system.

The CST system has continued to grow at a breathtaking rate. Wisconsin reported an increase of 34.8 percent in restoration commitments between 2011 and 2013; Hawaii, 35.8 percent between 2005 and 2009; Washington, 73 percent between 2010 and 2014; Los Angeles County, 48 percent between 2014 and 2015; and Oregon, 129 percent between 2012 and 2017.[21] In some jurisdictions, waiting

times for a CST evaluation may exceed a year, and adverse clinical outcomes mount as mentally ill inmates languish in jail.[21] Many states have been sued to provide services in a timelier fashion.

Treatment Limitations

Society devotes substantial resources to this forensic scheme to protect the integrity of the adjudication process. The outcomes, however, indicate scant benefits to mentally disordered offenders themselves. Assessments are dedicated to specialized evaluations of defendants' capacities to assist their attorney and to understand the adjudication process. In the event of hospitalization for restoration, treatment is largely limited to pharmacotherapy and to educational programs targeted to address gaps in knowledge about the legal process. The endpoint of forensic treatment and hospitalization is reached once a defendant achieves a minimal level of assessed competence. Practices vary across jurisdictions, but often the goals of typical civil hospitalization (i.e., achieving discharge readiness and arranging services to enable functioning in the community) are not pursued. Because these individuals are forensic patients, they "disappear" from community mental health services.[24]

The bottom line for present purposes is that the resources spent on competence assessment of seriously mentally disordered defendants make very little contribution to their well-being. They are not assessed for their needs with respect to discharge and transition planning for treatment, housing, transportation, or federal entitlements, and no plans are made for successful reentry into the community. This programmatic estrangement from integrated treatment is also physical. In most jurisdictions, forensic patients are cared for in specialized hospitals or on specialized wards where they have no contact with treatment systems (in-reach and out-reach programs) or supportive services that civil patients receive.[24]

The separation of the competence assessment process from the treatment needs of mentally disordered offenders is worsening. As the numbers of defendants with mental disorders have increased, the demand for CST evaluations and restoration services has also increased.[5] Many state forensic systems are in crisis. These systems have long waitlists for inpatient evaluations and restoration. About one-third of states have implemented jail restoration programs, which may help reduce unnecessary hospitalizations but also further attenuate the connection of disordered defendants to the public mental health system and their treatment resources.[21,25]

Ultimately, most disordered defendants will be returned to court for adjudication of charges. If convicted, defendants charged with lesser offenses will often be released for time served, with many defendants spending far more time involved in the forensic system than they would have spent in jail had the question of competency never been raised. As a result, most will be released with inadequate planning for their outpatient treatment needs or the provision of community supports. Florida, for example, spends more than $50 million annually restoring competence to defendants charged with nonviolent crimes who never spend a day in prison; many are released who have no housing, no means of support, and insufficient medication to span the time to an appointment.[26] Current policies governing competence assessment and restoration need reform; resources should be reallocated to the comprehensive care and treatment of offenders with serious mental disorders.

EDCOT Objectives

Against the backdrop of this disturbing portrait of pretrial competence assessment in the United States, we propose EDCOT, a new form of civil commitment designed to expedite the diversion of many offenders with mental disorders from the criminal process and into a civil pathway of mandated treatment. If the parties are motivated to make decisions promptly, EDCOT orders could be issued within weeks following arrest in many uncomplicated cases. Because the criminal charges would be dropped, EDCOT would not entail the delays and inefficiencies inevitably associated with competence assessment and restoration orders. In an earlier publication,[11] we presented a tentative sketch of EDCOT. We elaborate on these requirements below.

The fundamental goal of EDCOT is therapeutic. The commitment is a variation of ordinary civil commitment governed by the principles enunciated in *O'Connor v. Donaldson*[27] and *Addington v. Texas*[28]. When EDCOT varies from ordinary civil commitment, the difference lies in its role as a formal diversion from the criminal process. The origins of the commitment in criminal prosecution highlight the complementary role of the police power in what is

envisioned primarily as a therapeutic process rooted in the *parens patriae* authority of the state. The commitment criteria, including proof of criminal conduct and the contributory influence of mental illness, specifically take account of the ways in which respondents' behaviors affect public peace and security as well as their own well-being.

The features of contemporary civil commitment that are most germane to EDCOT commitments are those that entail mandatory outpatient treatment designed to reduce the risk of further deterioration, instability, or distress if the respondent remains untreated. One area where EDCOT is meant to be more aggressive and protective than ordinary civil commitment is in authorizing intensive intervention, including confinement, in response to noncompliance or other indicators of instability and possible relapse. Still, EDCOT is not envisioned as a risk-averse, incapacitative form of commitment analogous to commitment of persons acquitted by reason of insanity. For this reason, EDCOT commitment is not intended for use in the typical case involving a person charged with a serious violent offense such as murder or armed robbery.

In sum, EDCOT commitments focus on a subgroup of seriously mentally ill arrestees whose harmful or alarming criminal conduct is found by a court to be sufficiently related to a serious illness that they are likely to continue to offend in the absence of aggressive treatment interventions and social supports addressing criminogenic factors. In some cases, short-term safety risks associated with the individual's mental illness may independently justify ordinary civil commitment in a safe setting, but EDCOT is intended to apply more broadly and to include longer-term risk. Cases suitable for EDCOT are those in which significant criminal behavior associated with the illness justifies an intensive array of mandatory interventions designed to stabilize the individual's functioning and prevent future deterioration and recidivism. In our view, the longer-term risk associated with a deteriorating course of illness fully satisfies the accepted constitutional grounds for preventive intervention under contemporary mandatory outpatient treatment statutes.

EDCOT strikes a somewhat different balance of liberty and restraint than do the two primary civil models. On the one hand, EDCOT treatment and management would place a stronger emphasis on public order and prevention of future deterioration than the traditional civil commitment model. Similarly, EDCOT could feature more intense outpatient monitoring and quicker responses to noncompliance after hospital release than under ordinary civil commitments, thereby placing a greater emphasis on maintaining compliance with treatment. On the other hand, EDCOT would be more therapeutically oriented, and categorically less restrictive, than the typically risk-averse not guilty by reason of insanity management systems that usually err decisively in the direction of confinement and public protection.

EDCOT is designed to embody a problem-solving approach to management with the goal of supporting committed individuals so that they can function appropriately in the community. A strong emphasis would be placed on identifying stressors and triggers of problematic community behavior. Discharge planning, supervised treatment, and ongoing problem-solving are important features of EDCOT.

Unlike most diversion programs currently in place, this new pathway would represent a formal diversion from the criminal process. If it works as we intend, it will involve the formal termination of criminal proceedings, not a conditional disposition under which the charges could be resurrected as a result of noncompliance. Therefore, in the event of noncompliance, the consequences would involve problem-solving interventions, including short-term detention (including hospitalization if clinically indicated), but not criminal sanctions or punitive restraint.

EDCOT Process

EDCOT would be available procedurally upon a petition by the prosecution, although we expect that it would be a consensual disposition in most cases involving less serious offenses. Unless the necessary findings are stipulated, a formal hearing would be held at which the prosecution would be required to prove the commitment criteria summarized below. Upon commitment, criminal charges would be dropped. The prosecution would be entitled to file new criminal charges, however, in the event of reoffending by the patient during the period of the EDCOT commitment order.

Unlike current forms of diversion, EDCOT would provide inpatient and outpatient treatment options, applied on an individualized basis according to clinical criteria. The availability of inpatient commitment will facilitate expedited transfer of seriously

disordered inmates out of the jail setting. Outpatient treatment would have similarities with mandatory outpatient treatment currently available in many states. As indicated above, in the event of deterioration or a violation of specific terms of the commitment order, the individual would be subject to a detention order (and possible hospitalization) to allow for reassessment and treatment planning.

Our expectation is that, under EDCOT, many of the seriously mentally offenders now in jail would be diverted from the criminal process and into treatment rather than continuing in the criminal justice system to adjudication and incarceration.

In cases involving defendants whose competence to stand trial is in doubt, the decision to invoke this pathway ideally would be made early in the criminal proceedings, so that most mentally ill offenders would not enter the costly CST system and, therefore, would not be found incompetent to stand trial and committed for restoration. Instead, an EDCOT commitment hearing would be held without delay or negotiation and (as with an ordinary commitment hearing) without the need for the respondent's consent. (We anticipate that defense attorneys would support or accede to commitment in such cases, although the question requires further study.) Upon proof of the commitment criteria by clear and convincing evidence, the respondent would be committed, and the criminal charges would be dismissed.

We also envision a separate consensual process involving defendants whose competence to stand trial is not in doubt. For example, the prosecution and defense could stipulate that the EDCOT civil commitment criteria are met in an agreement analogous to those negotiated in traditional diversion programs. Upon issuance of the order, the criminal charges would be dismissed. Alternatively, the court could hold a hearing *sua sponte* on the matter and enter the order after making the necessary findings. Either way, we anticipate that consensual EDCOT orders would displace leveraged mental health court guilty pleas in many cases.

Initiating a Commitment

A request for an assessment of a detainee's eligibility for EDCOT commitment may be made by the prosecutor or by the court. A request for a CST evaluation (by either party or the court) would ordinarily be expected to trigger judicial consideration of the appropriateness of an assessment for eligibility for EDCOT commitment as an alternative course.

The mental health assessment required for commitment would be performed by the state department of mental health or its designee. These evaluations may be performed on an outpatient basis, including in jails and other detention facilities, or may be done at an appropriate designated inpatient facility. The length of commitment for evaluation should be short (e.g., no more than 30 days).

The initial mental health assessment would include determination of the presence of a mental disorder as well as a summary of past problematic behavior, including offending. In addition, the evaluator would provide an individualized assessment of risks and triggers for criminal behavior and other factors likely to affect the defendant's social adjustment. The treatment plan would address how the identified triggers and precipitants to problematic behavior would be addressed. The assessment would be based on mental health records and historical information provided by the court, the prosecutor, and the defense attorney.

Commitment Hearing

The commitment would be under the authority of the court with jurisdiction over the criminal case. EDCOT proceedings would follow current commitment requirements: right to notice, right to counsel, right to a hearing, proof by clear and convincing evidence, and the right to appeal, for example.

Commitment Criteria

The predicates for commitment would be a serious mental disorder as defined by state law for traditional civil commitment as well as proof by clear and convincing evidence that the person engaged in criminal conduct; the conduct was clinically related to a serious mental illness; there is a significant likelihood of future offending in the absence of treatment interventions; and there is a reasonable likelihood, based on expert evidence, that mental health treatment and accompanying community interventions and services will reduce the risk of reoffending.

This set of clinically grounded criteria should not be confused with the legal criteria associated with the insanity defense (e.g., substantially impaired capacity to appreciate the wrongfulness of the conduct or to conform the conduct to the requirements of the law).

Case example: Mr. Jones is a 25-year-old homeless man with a long history of chronic mental illness. He was arrested after he confronted an elderly couple on the street, yelled racial epithets, and punched a passerby who intervened. He is well known to the police and has been arrested more than two dozen times for disruptive and assaultive behavior. In some instances, charges have been dropped. When they have not, he has cycled through the CST and restoration system and been released for time served after restoration. Released from court, he has never had discharge plans other than being given a list of local public clinics where he might seek treatment. Outside jail and the forensic system, he has not received any mental health treatment or services. EDCOT provides a legal mechanism for the extended period of assertive outpatient treatment, social support, and oversight that he needs.

While extended discussion of the criteria would exceed the scope and ambition of this article, two points should be noted in passing. First, the criteria refer to occurrence of "criminal conduct." Technically, it is possible that the defendant who committed the *actus reus* of the offense lacked the *mens rea* because of mental illness or was not criminally responsible. Our present inclination is to say that the EDCOT statute should make it clear that such a person is committable under EDCOT. Second, a finding of dangerousness is not required under EDCOT; instead, the formal therapeutic intervention is warranted by any criminal behavior that breaches the peace or arouses public alarm, including (but not limited to) threatening or assaultive behavior.

Commitment Order

The EDCOT commitment order would identify the required services as well as designated providers and would specify classes of medication needed, as identified in the mental health assessment. The order would include clinically indicated inpatient and outpatient treatment and, as necessary, assertive community treatment, residential services, day treatment, and other community services or supports. The order would include estimates of the anticipated length of mandated treatment. The order also would indicate the treatment and service needs likely to be required following the termination of the commitment.

Judicial Monitoring

The court would review and approve the treatment plan, would monitor the implementation of mandated services specified in the order, and, if necessary, take steps to assure compliance and continuity of court-ordered care. We expect the EDCOT statute to authorize short-term custodial orders in the event of material noncompliance to provide an opportunity for assessment and intervention (as well as a deterrent to noncompliance). An appropriate person in the public mental health system would be designated to make periodic reports to the court regarding compliance with the order and any problems that may arise that jeopardize continuity of care or public safety.

In some jurisdictions, commitment to established mandatory outpatient treatment programs may be appropriate for individuals facing misdemeanor charges, if they are clinically indicated and provide sufficient oversight. A status hearing would be held periodically, but no less than once every six months, and the care and progress of the committed person would be thoroughly reviewed.

Length of Commitment

The order would be indeterminate in length up to a statutory ceiling (i.e., the typical arrangement for mandatory outpatient treatment orders under traditional civil commitment), although the ceiling on EDCOT commitment would be tied to the seriousness of the offense. Ideally, courts should make individualized judgments about the length of commitment on the basis of the committed person's therapeutic progress, the degree of their stability in the community, and other evidence of successful transition. There is evidence that mandatory outpatient treatment is most likely to be successful when sustained over periods of 18 months.[29,30] Of course, individuals may have differing needs; those with comorbid illnesses or other complicating social factors may need to be committed for a more extended period of mandatory care.

State legislatures will make different judgments regarding the proper balance of public safety and the liberty interests of offenders when setting the statutory limits for EDCOT commitments. The seriousness of the criminal conduct on which the order is predicated should play a role in determining the involuntary treatment period. We believe that the correct approach is to establish upper limits on the maximum period of EDCOT commitment on the basis of the underlying predicate offense. For misdemeanor offenses, the maximum period of mandated treatment should be one year. For those with

an underlying nonviolent felony charge, a period of three years should be appropriate in most circumstances and should be sufficient to bring prosecutors on board. For more serious felonies, a ceiling of five years may strike an acceptable balance. In any case, the length of commitment should not extend beyond the period of the maximum sentence the committed person would have received if convicted of the charged criminal behavior.

The commitment period would be terminated if there were a judicial determination that the individual is no longer in need of supervision for public safety reasons or is no longer in need of treatment. Conversely, the three traditional commitment pathways (ordinary civil commitment, CST commitment, and not guilty by reason of insanity commitment) would remain available if the intermediate pathway outlined in this article is not a good fit for a particular case.

Summary of EDCOT

The proposed EDCOT commitment law borrows familiar elements from contemporary civil commitment models, particularly those that concentrate on mandatory outpatient treatment. Although it is expected to be somewhat more restrictive than ordinary commitment laws, EDCOT commitment is driven primarily by therapeutic considerations and bears no resemblance to not guilty by reason of insanity commitment statutes and sex offender commitment laws that prioritize incapacitative considerations.

Adoption of this model does not preclude continued use of other local programmatic innovations, such as mental health courts and other diversion programs. Nonetheless, EDCOT commitment, as we have envisioned it in this article, differs in important ways from those valuable initiatives. As a commitment law, it provides a new path to involuntary treatment and would be applicable state-wide. State mental health agencies would, by necessity, be involved in making public inpatient beds available, likely those redeployed from CST restoration use. In addition, state agencies' resources would be needed to designate qualified examiners, provide training, and implement policies and procedures.

EDCOT would not be restricted to higher-functioning offenders who are capable of decision-making regarding adjudication and are ready for community placement. EDCOT can be applied to offenders with serious, current mental disorders with significant, active symptoms of mental illness, as well as those in need of drug or alcohol detoxification prior to treatment of primary psychiatric disorders.

Conclusion

It is time for the criminal justice system and public mental health agencies to rationalize the nation's approach to the care and management of individuals with serious mental illnesses who become involved in the criminal justice system. Under our proposal, a substantial proportion of such defendants would be diverted formally to a new form of civil commitment early in the criminal process and would thereafter receive care and be managed in treatment systems operated by state and community mental health authorities. These individuals would not be relegated to jails or prisons with uncertain prospects for care and the risks of victimization.

Our state and local mental health agencies would be able to reduce their outsized resource allocations to nonclinical responsibilities related to the CST system. Beds currently allocated to restoration of CST could be repurposed to core treatment functions. In addition, the costs of the new pathway of commitment would be offset by the elimination of criminal justice and forensic mental health expenditures. Assuming half of seriously mentally ill offenders were to follow this new pathway, the savings to the criminal justice system alone would be about $15 billion.[31] The new pathway would also save the public mental health system substantial sums. State forensic mental health divisions have become unsustainably enlarged to serve the interests of criminal adjudication. In 2014, the states spent nearly $9 billion for all inpatient services, of which $4.1 billion was spent for inpatient forensic services, 43.7 percent of the total.[22] This percentage has steadily grown over the years, increasing from 25.7 percent in fiscal year 2001 to 36.4 percent in fiscal year 2008.[22] Substantial reduction in the costs devoted to the CST process would free billions of dollars a year that could be targeted for treatment.

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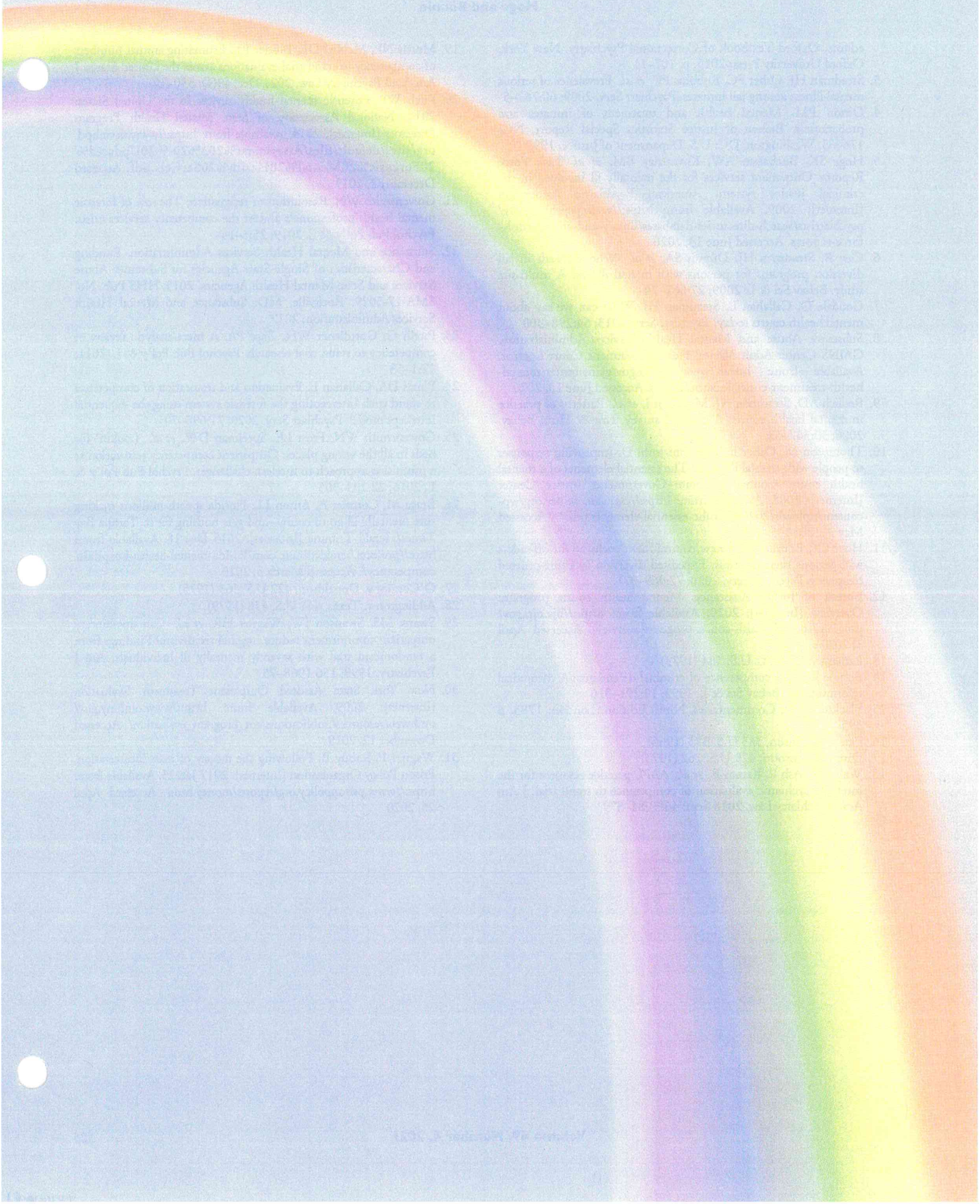

Rationality Was Lost on the United States Supreme Court in Its *Kahler* Decision

Alan R. Felthous, MD

In its recent *Kahler* decision, the U.S. Supreme Court ruled that Kansas' abolition of the state's insanity defense was constitutional. It did so by framing the matter as a choice between the state's *mens rea* defense and a moral capacity defense, then mischaracterizing the *mens rea* defense as a type of insanity defense. In analyzing the two approaches, the Court missed the fundamental importance of rationality in criminal mental responsibility, a constitutional requirement for other criminal competencies, and a condition well described in the Court's *Panetti* ruling. The Court's acceptance of the abolition of a special insanity defense is a public policy in the direction of further criminalizing and punishing rather than providing prompt and proper treatment to those with serious mental illness, at a time when increasing modern research demonstrates the success of insanity acquittee dispositions with improved treatment and management resulting in lower rates of relapse and criminal recidivism.

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The law does not expect people to perform functions that are beyond their capability. A number of functions cannot be performed until the individual has demonstrated legal competence, such as by obtaining a driver's license to operate a motor vehicle or a medical license to practice medicine. Other competencies are assumed unless the person has been legally determined to lack such competencies, such as competency to stand trial or to handle one's affairs. Where the specific tasks involve some independent capacity to think, such as the competence to make medical decisions or to stand trial, the capacity to think rationally can be critical.

Although the ideological and philosophical origins of the insanity defense are ancient,[1] prior to the 12th century criminal intent was not an element of a criminal offense in English law.[2] The first published insanity standard was that of Henry de Bracton in the 13th century: "An insane person is one who does not know what he is doing, is lacking in mind and reason and is not far removed from the brutes" (Ref. 3, p 1016). This first standard did not express a moral capacity, only a cognitive/rational capacity (i.e., lacking in mind and reason). Judge Tracy used a similar standard in the *Arnold* case of 1724 five centuries later.[4] The "good and evil test" of 1581, forerunner of a right and wrong test, was based upon rational incapacity (i.e., ". . . for they cannot be said to haft any understanding will").[5] The standard applied in the *Hatfield* trial of 1800 excused the defendant on the basis of the criminal act having been a product of a delusion, without reference to awareness of whether the act was wrong. This was a test of rational capacity, which was supported by defense attorney's Erskine's argument that ". . . it is the REASON OF MAN that makes him accountable for his actions; and that the deprivation of reason acquits him of crime" (Ref. 6, p 1310, emphasis in original).

The M'Naughten Rule of 1843 included moral capacity "or . . . that he did not know he was doing what was wrong" (Ref. 7, p 722), but both functional prongs of this rule were based upon the predicate of rational incapacity: "the party accused was laboring

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under such a defect of reason from disease of the mind" (Ref. 7, p 1843). In contrast to the first functional prong (i.e., "did not know the nature and quality of the act he was doing"), the cognitive capacity concept of the U.S. Supreme Court in *Kahler*,[8] the moral capacity (see below) relied on a "rational" capacity that was less narrow and restrictive than such cognitive capacity alone, yet included the defect of reason of psychosis.

In the first half of the 20th century, an insanity defense with the M'Naughten standard was essentially the law of the land in the United States. In the latter half of the century, half of the states replaced this with the standard of the American Law Institute (ALI), with its cognitive and volitional prongs.[9] The so-called cognitive prong of the ALI standard can be considered as in line with rational capacity, especially with its qualifier "lacks substantial capacity . . . to appreciate the criminality/wrongfulness of his conduct . . . ."[9] The second (or volitional) prong is an inability "to conform his conduct to the requirements of the law."[9] Both of these disjunctive functional criteria must be the "result of mental disease or defect."[9] Several states later changed their insanity standard back to M'Naughten without the volitional standard but excluded antisocial personality disorder by the "Second Paragraph" of the ALI[10] standard: "The terms 'mental disease or defect' do not include abnormality manifested only by repeated or otherwise antisocial conduct."[9]

The *mens rea* of a crime, whether specific or general, is simply the statutorily required mental component of the crime.[11] Like the criminal act itself (the *actus reus*), the specific *mens rea* (e.g., criminal intent) must be proven by the prosecution beyond a reasonable doubt. Although this may seem a demanding standard, prosecutors are afforded much latitude in the use of circumstantial evidence, and the trier-of-fact may have little trouble arriving at a conclusion. In practice, a steeper hill to climb is the task of the defense to establish lack of intent (or lack of *mens rea*) due to a mental disorder. In most U.S. jurisdictions, a special affirmative insanity defense enables the defense to present a more complete explanation of the defendant's mental disorder and how the disorder impaired the defendant's capacity to have the guilty mind (or *mens rea*) required to have committed the offense. Unlike its position concerning other criminal competencies, the U.S. Supreme Court in *Kahler v. Kansas*[8] did not consider rationality to be a required aspect of the requisite *mens rea* when it found the abolition of a special affirmative insanity defense in Kansas to be constitutional. The Court simply did not consider rationality *per se*.

The Court's Opinion in *Kahler*

Kahler v. Kansas concerned the defense in a domestic homicide case. Karen Kahler moved out of the home with her two adolescent daughters and nine-year-old son in 2009 when she filed for divorce from James Kahler. James Kahler became increasingly distraught over the ensuing months. He drove to Karen's grandmother's home, where Karen and the children were residing, and entered through the back door. He first shot Karen, allowing his son to escape. Moving through the house, he then shot Karen's grandmother and his two daughters successively. All four died. The following day he surrendered to police and was charged with capital murder.[8]

Kansas law states that "[i]t shall be a defense to a prosecution under any statute that the defendant, as a result of mental disease or defect, lacked the culpable mental state required as an element of the offense charged."[12] According to this statute, "[m]ental disease or defect is not otherwise a defense." A defendant can then present evidence of "any mental illness" as evidence that he "did not have the intent needed to commit the charged crime" (Ref. 8, p 1025). Mr. Kahler filed a pretrial motion in which he argued that Kansas had "unconstitutionally abolished the insanity defense" and thereby allowed the conviction of a "mentally ill person 'who cannot tell the difference between right and wrong'" (Ref. 8, p 1027), and this violated the Fourteenth Amendment's Due Process Clause. The trial court denied this motion, and the jury convicted Mr. Kahler of capital murder. At the sentencing hearing, the jury imposed the death penalty.

On appeal to the Kansas Supreme Court, Mr. Kahler argued that Kansas' approach to his claims was unconstitutional. Citing an earlier precedential decision, the Kansas Supreme Court rejected his argument and maintained that the insanity defense is not so "'ingrained in our legal system as to count as 'fundamental'" (Ref. 8, p 1027, citing *Kahler v. Kansas* (2018),[13] which in turn quoted from its decision in *State v. Bethel*[14]). Therefore, "[d]ue process does not mandate that a State adopt a particular insanity test" (Ref. 14, p 851).

In turning to the U.S. Supreme Court, Mr. Kahler asked the Court to decide whether the Due Process Clause requires an insanity defense that allows acquittal if the defendant could not "distinguish right from wrong" at the time of the crime. In other words, does the Due Process Clause require states to "adopt the moral-incapacity test from *M'Naughten*" (Ref. 8, p 1027), that is, "whether his illness rendered him 'unable to understand his action [was] wrong'" (Ref. 8, p 1025, citing *Clark v. Arizona*,[15] p 2709). The Supreme Court held that the Due Process Clause does not require states to adopt the moral incapacity test from *M'Naughten*.

The Court's Opinion

Writing for the majority, Justice Kagan held that due process does not require states to adopt an insanity test that depends on the defendant's recognition of the moral wrongfulness of the crime. Although Kansas abolished its special affirmative insanity defense, the state nonetheless provided the defendant with a mental defense, a *mens rea* defense, whereby the defendant could present evidence to disprove the mental state required by the specific offense. Moreover, after conviction a defendant in Kansas is also afforded the opportunity to present evidence of mental illness at sentencing that could raise reason to find him "not fully culpable and to lessen his punishment" (Ref. 8, p 1026). Such evidence could also convince the court that the defendant is in need of psychiatric care and transfer him to a "mental health facility rather than a prison" (Ref. 8, p 1026). In this way a defendant, who in another state may have been acquitted on the basis of insanity, could end up in the "same kind of institution" (Ref. 8, p 1026).

The Court presented from *Clark*[15] four "strains" of insanity defense standards in the United States. The cognitive capacity standard is where the defendant did not know what he was doing when he committed the offense. The moral capacity standard is met where the defendant did not understand that his act was wrong. The volitional capacity standard is met where the defendant's mental illness rendered him unable to control his criminal behavior. Finally, the product-of-mental-illness test can be excusing if the defendant's criminal act resulted from his mental illness.[8]

Although Kansas no longer has a moral capacity standard, it nonetheless has a cognitive capacity test that is embodied in its *mens rea* defense, which the Court likened to the "nature and quality" prong of the M'Naughten standard: "As everyone here agrees, Kansas law thus uses *M'Naughten's* 'cognitive capacity' prong—the inquiry into whether a mentally ill defendant could comprehend what he was doing when he committed a crime" (Ref. 8, p 1026). "Kansas has an insanity defense negating criminal liability" (Ref. 8, p 1030) in the form of the cognitive capacity defense by which the defendant can disprove the criminal mental state that defines the crime.[8]

Mr. Kahler argued, citing the U.S. Supreme Court's rule in *Leland v. Oregon*,[16] that the moral incapacity standard is a "principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental" (Ref. 8, p 1030). Moreover, the moral incapacity standard is the "'single canonical formulation of legal insanity' and thus irreducible 'baseline for due process'" (Ref. 8, p 1030, citing *Clark*,[15] p 2722). Citing this same rule, the Court stated, ". . . a state rule about criminal liability—laying out either the elements or the defenses to a crime—violates due process only if it 'offends some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental'" (Ref. 8, p 1027, citing *Leland*,[16] p 798). The Court concluded that the Kansas approach did not offend such a principle and did not violate due process. The Court arrived at their conclusion by applying this standard and examining "historical practice" (Ref. 8, p 1027, citing *Montana v. Egelhoff*,[17] p 2013).

The majority cited several early common law commentators such as de Bracton, whose so-called wild-beast test focused more on whether the defendant "had the ability to do much thinking at all" (Ref. 8, p 1033). If the defendant cannot think enough to form an intention, he cannot be guilty. From the Supreme Court's analysis, the M'Naughten test "disaggregated the concepts of cognitive and moral incapacity, so that each served as a standalone defense" (Ref. 8, p 1035).

The Supreme Court further emphasized the diversity of different insanity standards used by the 50 states and observed that several no longer require a moral capacity component.[8] Five states have laws like that of Kansas, and another 16 states' laws would also be found to be unconstitutional if the Kansas law were found to violate due process for want of the moral capacity standard. The latter would be due to the fact that these 16 states required that the

defendant be unable to understand that the act was criminal, not that it was morally wrong, to qualify for the insanity defense.

The Dissent

The dissenting opinion, written by Justice Breyer and joined by two other justices, Ginsberg and Sotomayor, found the opposite. "Seven hundred years of Anglo-American legal history, together with basic principles long inherent in the nature of the criminal law itself, convince me that Kansas' law offends . . . principles of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental (Ref. 8, p 1038, citing *Leland*,[16] p 798, citing *Snyder v. Massachusetts*,[18] p 105).

Breyer cited the four leading common law jurists, as had the majority: de Bracton, Coke, Hale, and Blackstone. Each "linked criminality to the presence of reason, free will, and moral understanding" (Ref. 8, p 1040). de Bracton, author of the first wild-beast test of insanity, described the "madmen" who cannot be found criminally responsible as being "without sense and reason and lack[ing] *animus*" (Ref. 8, p 1040, citing de Bracton,[3] pp 324, 424). Sir Matthew Hale based criminal liability on "understanding and liberty of will" (Ref. 8, p 1041, Ref. 19, pp 14–5). Lambard in 1581 (Ref. 5, p 218) and Hawkins in 1716 (Ref. 20, § 1, p 2) found that criminal responsibility rested on the ability to distinguish good from evil, which in turn required "understanding." Coke agreed on the need to be able to discern right from wrong (Ref. 8, p 1040). Sir William Blackstone in the 18th century explained that "[p]ersons suffering from a 'deficiency in will' arising from a 'defective or vitiated understanding' were not [criminally] chargeable for their own acts" (Ref. 8, p 1040, citing Blackstone,[21] p 24). Similar to such landmark common law cases, treatises by English legal scholars adopted the same view that the insanity standard hinges on the defendant's capacity to distinguish good from evil or right from wrong and to act with a free will or as a free agent and with moral understanding.[1]

The dissent noted that, in the landmark case *Rex v. Arnold* (1724), the court stressed that Justice Tracy instructed the jury: If a defendant is "deprived of his reason, and consequently of his intention, he cannot be guilty" (Ref. 8, p 1042, citing *Arnold*,[4] p 764). From this, the majority had concluded that the *Arnold* court "adopted a modern *mens rea* test" (Ref. 8, p 1042). Yet the immediately preceding passage more clearly established Judge Tracy's meaning: the questions for criminal responsibility include whether the defendant "could not distinguish between good and evil and did not know what he did" (Ref. 8, p 1042 citing *Arnold*,[4] p 764). "If a man be *deprived of his reason, and consequently of his intention, he cannot be guilty* . . ." (Ref. 8, p 1042, citing *Arnold*,[4] p 764, emphasis in original).

Citing contemporary mental health law authorities Slobogin[22] and Morse,[23] the dissent stated that examples of a defendant having killed a person under the belief that the victim was a dog, thereby negating criminal intent to kill a person, are rare, ". . . because mental illness typically does not deprive individuals of the ability to form intent. Rather, it affects their *motivations* for forming such intent" (Ref. 8, p 1048, emphasis in original).

In *Clark v. Arizona*,[15] the U.S. Supreme Court upheld Arizona's new insanity standard, which had eliminated the first part of the M'Naughten rule but maintained the second. In the *Kahler* case, Kansas asked if Arizona can eliminate the first part of M'Naughten, the ability to know the "nature and quality of the act," why cannot Kansas eliminate the second part concerned with moral incapacity (Ref. 8, p 1049, citing *Clark*,[15] pp 747–8). The minority's answer was that the "[e]vidence that the defendant did not know what he was doing would also tend to establish that he did not know that it was wrong" (Ref. 8, p 1049, paraphrasing *Clark*,[15] pp 753–4). Moreover, Arizona, unlike Kansas, did not eliminate the insanity defense, limited as it was.

With regard to the opportunity that Kansas allows a defendant to present evidence of mental illness at sentencing, the dissent maintained, "[O]ur tradition demands that an insane defendant should not be found guilty in the first place" (Ref. 8, p 1049).

Rationality and Criminal Responsibility

The argument in *Kahler*, as framed by the U.S. Supreme Court, was not whether abolition of the insanity defense unconstitutionally violated the Due Process Clause; rather it was whether the unavailability of a moral capacity test violates the Due Process Clause. The Court found that Kansas has a *mens rea* defense whereby a defendant can present evidence of mental illness to negate criminal intent. Without concluding what, if anything, would be constitutionally required for due process, the Court found that a

moral capacity standard was not required. It seems the Court was presented with a dichotomous choice: moral capacity, advocated by the defendant and several *amici curiae* briefs, versus cognitive capacity alone, wherein cognitive capacity can be limited to the specific *mens rea* of the offense charged, typically meaning the requisite criminal intent (i.e., the only mental defense in Kansas). A third option, one that should be seen as well rooted in the traditions and consciousness of our people, was not considered: rational capacity.

At first glance, the *Kahler* majority opinion appears to have adopted the classification of insanity defenses presented in *Clark*, but this impression obfuscates the critical, substantial differences in both conceptualization and application of the two classifications. The *Clark* classification, in the opinion written by Justice Sotomayor (who in *Kahler* joined the dissenting minority), was truly one of insanity defense standards. In departure from this, *Kahler* extended the application of the *Clark* cognitive capacity to a *mens rea* defense and thereby conflated a *mens rea* defense with the first functional prong of the M'Naughten rule, lumping them together as one "cognitive capacity." In *Clark*, however, the Court, although distinguishing the two capacities in its classification, observed that many (but not all[24]) courts find the cognitive and moral capacities to be equivalent (Ref. 15, p 2723). Within this conceptualization, the narrowest cognitive prong of M'Naughten involves rationality. But the *Kahler* Court, in contrast to its view in *Clark*, unequivocally excluded moral capacity from cognitive capacity. In arguing against the moral capacity argument made by the defendant, the dissent, and multiple *amici curiae*, the majority dismissed the psychological, legal, and moral importance of psychotic motivation and of rational incapacity, which Morse[25] described and supported as the fundamental traditional and modern defect that allows acquittal on the basis of mental disorder.

If the U.S. Supreme Court overlooked rationality as necessary to criminality, it also did not define rationality or reason. Definitions vary widely and include the vague and simple ability to think as well as the higher, more specific capacity to think logically. The Court's own explanation of rationality in *Panetti*[26] would be the most appropriate in this context of criminal mental responsibility. Black's Law Dictionary provides the following definition of reason: "A faculty of the mind by which it distinguishes truth from falsehood, good from evil, and which enables the possessor to deduce inferences from facts or from proposition" (Ref. 27, p 1431). Lacking this level of reason would be more consistent with the *Panetti* irrationality criterion than the near inability to think at all criterion of the *Kahler* decision.

In philosophy, concepts and terminology are different from common usage but pertain to criminal mental responsibility: "In its primary sense, rationality is a normative concept that philosophers have generally tried to characterize in such a way that for any action, belief, or desire, if it is rational, we ought to choose it" (Ref. 28, pp 772–3). Two categories of rationality are recognized, instrumental and theoretical. Instrumental rationality corresponds to instrumental capacity, the ability to carry out an act to achieve one's goal. This is essentially the cognitive capacity of *Kahler*, i.e., the capacity of criminal intent. Theoretical rationality is where a belief is irrational if it conflicts with what one should know. Where the irrational belief is a delusion, theoretical irrationality is, for purposes of criminal responsibility, what is considered irrational or, in our terminology, lacking in rational capacity.[28]

Rationality in Criminal Competencies

Criminal and civil competencies are intended to ensure that individuals can do what they are expected to do; people are not expected to perform tasks that they cannot do. The U.S. Supreme Court emphasized the importance of rationality for specific functions that a defendant may need to perform in judicial processes involving trial and sentencing. Even if most states did not explicitly require rationality at the time of the Court's *Dusky*[29] decision, and even if most state laws today, long after *Dusky*, do not explicitly require rationality,[30] the U.S. Supreme Court introduced rationality into the two-pronged common law standard for competence to stand trial by way of its model, which is known as the *Dusky* standard for competence to stand trial: "the test must be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as a factual understanding of the proceedings against him" (Ref. 29, p 402). Even if the defendant has a factual understanding of the proceedings, his understanding can still be irrational and render him incompetent if he believes, for example, that the judge is a Martian alien disguised as a judge

who intends to have him transported to the planet Mars. It is reasonable to assume that, in states which have not incorporated the term "rational" into their competency statute, the trial courts would consider rationality, as they typically do, when deliberating whether a defendant is competent to stand trial.[30]

Likewise for criminal sentencing, in particular the imposition of the death penalty, the U.S. Supreme Court requires more than just the person's awareness that the sentence would lead to death. In 1986 in *Ford v. Wainright*,[31] wherein the Court required competence to be executed, it indicated that the defendant must be aware of the trial court's rationale in imposing the death penalty. Eventually, in *Panetti v. Quarterman*, the Court in 2007 required a more substantial understanding of the nature of the death penalty and why it is being imposed. In a word, the Court's word, the defendant's understanding must be "rational" if the defendant is to be considered competent to be executed.[26] Although the Court did not formulate a standard for execution competence in this decision, it provided a meaningful description of what is meant by rationality for the purpose of execution competence.

Scott Louis Panetti had killed his parents-in-law, held his wife and daughter hostage, and then surrendered to police. The U.S. Supreme Court cited testimony of an expert witness who apparently illustrated how lack of rationality may have rendered Mr. Panetti incompetent for execution. Space does not allow for iteration of the Court's description of the quality and extremity of irrationality that could render a defendant incompetent for execution. For this account of the nature of Mr. Panetti's psychosis and how his delusions, especially his delusion that his execution was spiritual warfare, distorted his understanding of the reason for his execution, the reader is referred to the opinion itself. The Court concluded, "A prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it" (Ref. 26, p 2862). Moreover, this qualifying irrationality is due to a severe mental disorder, "not a misanthropic personality or an amoral character," but rather, "a psychotic disorder" (Ref. 26, p 2862).

In *Panetti*, the U.S. Supreme Court noted the reliance of a fundamental purpose of criminal punishment, retribution, on rational competence. Whether "'retribution is served' is called into question . . . if the prisoner's mental state is so distorted by a mental illness that his awareness of the crime and punishment has little or no relation to the understanding of those concepts shared by the community as a whole" (Ref. 26, p 2861). If retribution is a fundamental purpose of punishment, it is as well a fundamental purpose and justification for the finding of criminal guilt. Therefore, if rational competence is required for imposition and execution of capital punishment, rational competence to have committed the offense should be no less important. The Supreme Court has established the necessity of rational competence in support of the criminologic purposes of retribution and secondary deterrence, i.e., deterring others by example from committing the same offense, for capital punishment. Mental criminal responsibility without rational understanding is oxymoronic, unreasonable, and inconsistent with the Supreme Court's own understanding of the meaning of retribution, as the Court well explained in *Panetti*.

Even as they support an insanity standard based upon moral capacity, mental health law authorities,[22,23,32–34] mental health,[35] and law[36] organizations emphasize that the requisite moral capacity must be based upon rationality. This position was well represented among the several *amici curiae* briefs submitted in *Kahler*.[34–36]

The Court Misapplied Principles of Fairness

Having misdefined a *mens rea* defense as an insanity defense from which rationality was removed, the U.S. Supreme Court misapplied trial and execution competencies to justify the abolition of a special insanity defense. The Court argued that fairness was afforded the defendant, even without what most would consider an insanity defense, because the defendant was allowed to present evidence of mental illness at a competency hearing or at the sentencing hearing for execution. Although all three types of competency (trial, criminal responsibility, and execution) are supported by the requirement for due process, these three determinations serve different purposes, have different criteria, and pertain to different times. The determination of one type of criminal competence does not equate to the determination of the other types of criminal competencies. Thus, the majority's contention that the defendant's opportunities to argue for trial and execution incompetence compensates for his not having an actual insanity defense available is more obscuring than clarifying of the three types of competency. The more important point, lost on the Court, is that

criminal competencies require rationality, and criminal competencies should logically include competence to commit a crime.

I have argued against expanding the insanity defense to include psychopathic disorders out of concern for, among other reasons, the insanity defense's (even for psychotic disorders) being under attack and at risk of abolition.[37] Public policy takes relevant scientific information, then sets the threshold in the form of normative standards as to when impairment of the will or rationality is of sufficient quality and degree to qualify for the insanity defense.[38] For well over half a century, the U.S. Supreme Court has deferred to the states to set their own insanity standards. Unsurprisingly, states continued to evolve different insanity standards. The Court in *Kahler* then used this diversity to suggest that there is little consensus in public policy as to what if any standard should be required. With regard to psychopathic disorders, the Court seemed to find inconsistency in that states' insanity standards prohibit psychopaths, who may because of their disorder be unable to recognize that their crimes are immoral, from raising the insanity defense (Ref. 8, Fn 12, p 1036). But the "irrationality" of the psychopath is not the essentially psychotic irrationality that the Court itself found disqualifying for execution.

In emphasizing the diversity of insanity defenses and thereby diminishing their importance, the U.S. Supreme Court overlooked the unifying factor of rationality in criminal responsibility. The Court distinguished criminal understanding from moral understanding of wrongfulness in state insanity standards, yet in either case it is the irrational incapacity to know or appreciate that the act was wrong. The criminal wrongfulness is another species of moral incapacity, not to be equated to a strictly *mens rea* awareness, as the Court seems to have done. Defendants who lack "criminal moral capacity" may or may not know what act the criminal law prohibits; what they irrationally do not know is that their acts violated the law. Thus, a delusional belief that one was acting in self-defense could qualify as lacking either criminal or personal moral capacity. In either case, it is the psychotic irrationality that is the fundamental and widely appreciated defect that renders a defendant criminally incapacitated.

If the U.S. Supreme Court were not so hyperfocused on the diverse aspects of insanity standards among the states, it might have noticed a common requirement, explicit or not, in all insanity defenses, even those without a "moral" component: profound disturbance in rationality, not simply unawareness of what physical act the person was performing. The Court's neglect of rationality was selective for criminal mental responsibility.

Disposition of Insanity Acquittees

The U.S. Supreme Court found that the lack of an insanity defense involving some modicum of rationality does not offend fundamental fairness. According to *Kahler*, a person could be adjudicated guilty of a criminal act committed despite an extremely pathological thought process the person could not control. The Court rendered this opinion when rationality, even more so than moral capacity requiring rationality, is so obviously rooted in contemporary insanity jurisprudence and scholarly legal commentary as well as historical tradition. Without adequate explanation, one cannot help but wonder if unexpressed concerns were involved in the Court's acceptance of abolition without considering rationality. Such concerns may have also influenced the Kansas legislature, and perhaps three other state legislatures, to have abolished the state's insanity defense in the first place.

The first concern is the public policy context, wherein abolition of the insanity defense is but one step in several over recent decades that promote criminalization of those with serious mental illness. Custodial prison care is more economical than intense inpatient mental health services. Other public policies that, in effect, favor punishing rather than providing an acceptable standard of treatment for such individuals include those that result in a decreasing availability of intermediate and long-term hospital beds, limited outpatient and community mental health services, and unavailability of hospital beds for incarcerated criminal defendants and sentenced prisoners. Arizona's recent defense/verdict of "guilty and insane,"[39] allowing for imprisonment following hospital treatment, together with the four states that abolished their insanity defenses, would be another example of punishing rather than appropriately treating individuals with serious mental illness.

Understandable is the public and political concern that mentally ill offenders who are acquitted as not guilty by reason of insanity and are not imprisoned, but hospitalized and eventually released, could discontinue their medicines, experience a relapse of

their mental disorder, and commit other crimes. What has received too little attention in media is the remarkable success of insanity restoration programs, which include a spectrum of mental health services, including, as needed, treatment in a secure hospital for an adequate period to permit substantial improvement, graduated step-down procedures to less secure placements, and conditional release with close supervision and proactive community treatment. Measures demonstrating success include fewer postdischarge rehospitalizations, fewer revocations of conditional release, and lower rates of criminal recidivism.[40–45] Rehospitalization due to relapse is less common in these programs than following brief civil hospitalization in the community, and criminal recidivism is far lower than that observed in offenders who are released from prison.[40–45] Therefore, with modern treatment and management programs for insanity acquittees, the risk to the community is substantially less than if the same offenders had been found guilty and sent to prison without the possibility of an insanity defense.

Conclusions

The earliest insanity standards in Anglo-American jurisprudence, based on the primitive understanding of mental illness at the time, described extraordinarily extreme conditions and compared them to the mental capacities of wild animals. Eventually criminal responsibility would require a sufficiently functional will (i.e., the intentional/decisional faculty), which in turn required rationality (i.e., thought processes that are sufficiently organized and grounded in reality).[38] As a minimum requirement for criminal mental responsibility, rationality is found in the M'Naughten and ALI standards for insanity, and the vast majority of states use one or the other or a modification of one or the other as their insanity standard. Although professional organizations and mental health authorities may argue for an even broader standard, the vast majority accept, as a basic minimum, the necessity of rationality.

In framing this as a choice between a *mens rea* defense alone and an insanity defense based upon moral capacity, the U.S. Supreme Court all but overlooked the fundamental and time-tested core element of rationality, which it had found constitutionally required for other types of criminal competencies. Not to be missed in this disappointing decision is that, just as states may restrict or even abolish their insanity defense, they also remain free to retain their insanity defense and, with this, the moral integrity of criminal law as well as the possibility for improved mental health outcomes for insanity acquittees and community safety.

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